Client Intake Form

Client Information			**Today's Date:**
Name			
Date of birth			
Address	Zip Code		
Cell number		Work Number	
Email Address		Okay to contact via email: circle one	Yes No
Referred by			
Emergency Contact Name		Emergency Contact Phone Number	
Do you give permission to contact person above in an emergency?			
Primary Care Doctor			
Current Medications			

If you are using insurance please complete bottom portion:

Insurance ID#	
Insurance Group #	
Subscriber Name	
Subscriber's Social Security Number	
Subscriber's Date of Birth	
Subscriber Address	
Subscriber Phone #	
Name of subscriber's employer	
Insurance Plan name	

Employment	
Current Employer	
Position	
List any work issues	

Substance Use/Abuse			
Have you used any of the following substances?	Date of last use	Frequency of use	Other information
Alcohol Y / N			
Marijuana Y / N			
Hashish Y / N			
Cocaine / Crack Y / N			
Narcotics / Heroin Y / N			
Hallucinogens / PCP LSD Y / N			
Amphetamines / Speed Y / N			
Barbiturates/Tranquilizers Y / N			
Inhalants Y / N			
Diet Pills Y / N			

History of treatment			
Have you received counseling in the past?	Yes / No	Number of times?	
Have you participated in substance abuse treatment in the past?	Yes / No	Number of times?	

40 Question Survey

INSTRUCTIONS: READ EACH ITEM BELOW CAREFULLY AND DECIDE *HOW MUCH* YOU HAVE EXPERIENCED EACH SYMPTOM *IN THE LAST MONTH. CIRCLE* THE APPROPRIATE RESPONSE.

0= Not at all 1= A little bit 2= Moderately 3= Quite a bit 4= Extremely

1. Headache	**0**	**1**	**2**	**3**	**4**
2. Nervousness or shakiness inside	0	1	2	3	4
3. Feeling critical of others	**0**	**1**	**2**	**3**	**4**
4. Trouble remembering things at work	0	1	2	3	4
5. Feeling easily annoyed or irritated	**0**	**1**	**2**	**3**	**4**
6. Feeling low in energy or slowed down	0	1	2	3	4
7. Feeling that most people can not be trusted	**0**	**1**	**2**	**3**	**4**
8. Poor appetite	0	1	2	3	4
9. Crying easily	**0**	**1**	**2**	**3**	**4**
10. Temper outbursts that you could not control	0	1	2	3	4
11. Blaming yourself for things	**0**	**1**	**2**	**3**	**4**
12. Feeling blocked in getting things done	0	1	2	3	4
13. Feeling lonely	**0**	**1**	**2**	**3**	**4**
14. Worrying too much about things	0	1	2	3	4
15. Feeling no interest in things	**0**	**1**	**2**	**3**	**4**
16. Feeling fearful	0	1	2	3	4
17. Your feelings being easily hurt	**0**	**1**	**2**	**3**	**4**
18. Feeling others do not understand you or are unsympathetic	0	1	2	3	4
19. Feeling that people are unfriendly or dislike you	**0**	**1**	**2**	**3**	**4**
20. Heart pounding or racing	0	1	2	3	4
21. Feeling inferior to others	**0**	**1**	**2**	**3**	**4**
22. Drinking more alcohol than usual	0	1	2	3	4
23. Trouble falling asleep	**0**	**1**	**2**	**3**	**4**
24. Having to check and double-check what you do	0	1	2	3	4
25. Difficulty making decisions	**0**	**1**	**2**	**3**	**4**
26. Your mind going blank	0	1	2	3	4
27. Trouble concentrating at work	**0**	**1**	**2**	**3**	**4**
28. Overeating	0	1	2	3	4
29. Sleep that is restless or disturbed	**0**	**1**	**2**	**3**	**4**
30. Difficulty getting the job done	0	1	2	3	4
31. Having urges to break or smash things	**0**	**1**	**2**	**3**	**4**
32. Feeling very self-conscious with others	0	1	2	3	4
33. Others not giving you proper credit for your achievements	**0**	**1**	**2**	**3**	**4**
34. Shouting or throwing things	0	1	2	3	4
35. Feeling pushed to get things done	**0**	**1**	**2**	**3**	**4**
36. Thoughts of ending your life	0	1	2	3	4
37. Never feeling close to other persons	**0**	**1**	**2**	**3**	**4**
38. Feelings of guilt	0	1	2	3	4
39. Needing a medication or using drugs more	**0**	**1**	**2**	**3**	**4**
40. Having problems with co-workers	0	1	2	3	4

Informed Consent to Treatment

The purpose of this form is to acknowledge voluntary consent to treatment by the clinician assigned to you by St. Louis Counseling & Wellness listed below. By signing this form you are agreeing with the following:
I acknowledge that I am voluntarily receiving service from Teresa Kleffner, LCSW. I understand that I can discontinue services at any time.
I understand that information shared with the named clinician will be held in the strictest of confidence. I give my permission for the following disclosures of information:

- CLINICAL SUPERVISION: To ensure quality of care, I understand that my information may be discussed with a clinical supervisor to assist in clinical development with the intent to improve clinical services.
- AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS: I authorize St. Louis Counseling & Wellness to release all necessary information to any insurance company, employee assistance program, health plan or other entity (third party payor) which may be responsible for paying for my care. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to St. Louis Counseling & Wellness and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.
- PAYMENT FOR SERVICES: In return for services to be provided by St. Louis Counseling & Wellness, I promise to pay for services rendered by St. Louis Counseling & Wellness to me or for my benefit. If the services I receive from St. Louis Counseling & Wellness are covered by a third party payor (EAP, insurance, etc.), St. Louis Counseling & Wellness may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.

I understand that my information may not be released without my written consent with the following exceptions:

- I present a danger to myself or someone else
- Actual or suspected child abuse or neglect. (Clinician named above is a mandated reporter.)
- Valid court order requesting records
- Appropriate discussion of case with other professionals for consultation or supervision

I agree to pay an appointment fee of $35 if I fail to give 24 hour notice to cancel an appointment.
_____ ~~(initial here)~~ Not applicable because you are using EAP. Please still give 24 hours if you need to cancel.

I acknowledge that I have received a copy of "Notice of Privacy Practices" with this Informed Consent to Treatment. I may revoke this consent in writing at any time.

_____	_____	_____
Client's Printed Name	Client's Signature	Date
_____	_____	_____
Witness Printed Name	Witness Signature	Date